Summary

The health, social and local authority organisations of Barking and Dagenham, Havering and Redbridge (BHR) propose to pilot creating an Accountable Care Organisation (ACO) for the 750,000 population they serve; as set out in The London Proposition submitted to Government in September 2015, and in line with NHS England’s New Models of Care Programme. The BHR region includes pockets of high deprivation and some of the very youngest, oldest and most transient populations in London; all aspects that have an effect on the overall health of the region. The current health and social care system constrains improvements in both quality and value for money, and as the unsustainable financial situation continues to worsen, the ability to take steps to improve care is further restricted. The core obstacles to dealing with the challenges faced by the region are the conflicting responsibilities, priorities and funding of the individual bodies currently involved.

In line with the direction of the national new models of care programme and the latest academic thinking on best practice, partners in BHR are convinced that coming together with a shared purpose to create and pilot an ACO framework will work in the best interests of the population by providing greater value for money and better co-ordinated, higher quality care. This is a major contribution to addressing the £22bn funding challenge across the NHS, specifically including the 20-30% of inpatients who would be better cared for in an out-of-hospital setting.

The ACO will remove commissioner-provider distinctions by taking ownership of the combined health and social care budget (£1.2bn is the combined total across BHR health, adult social care and public health spend) to deliver improved outcomes for the population. This will be achieved through cross-boundary and partnership working, reduced fragmentation, and investment in primary care and prevention, earlier intervention and supporting independence and wellbeing, alongside addressing the future sustainability of the health and care system.

This paper provides an overview of BHR’s proposal, and the required enablers for successful implementation over a three-year programme. The proposal has been developed in partnership by nine organisations: the three local authorities (the London Boroughs of Barking and Dagenham, Havering and Redbridge), the GP federations, Barking, Havering and Redbridge University Hospitals NHS Trust, North
The ask

Critical to the success of this pilot will be fundamental shifts in regulation, financial management and workforce across the health and social care system. Through this proposal the partners are seeking support to continue to co-develop these changes with national bodies such as the Care Quality Commission, NHS Improvement, and Health Education England, in tandem with NHS England and the national vanguards. We are also seeking financial support of £750,000 to establish a team and enable the co-creation of a detailed business case for the creation of the ACO in partnership with primary care practitioners and staff across BHR. This investment will be match funded through local resource from the nine partners.

Context

The three widening gaps identified in the Five Year Forward View, are as relevant (or more so) in BHR as they are in other areas of England. The table below gives a brief overview of the challenges:

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Population</th>
<th>Disease prevalence</th>
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| Health and wellbeing challenges | Fast growing population projected to increase by over 110,000 in the next 10 years (a 15% increase by 2025); within this there are significant forecasts in both 0-19 and over 75 year olds – above the London average | Delayed diagnosis  
  – High rates of late diagnosis of cancer and the second worst one-year survival rate in London (63.9% in B&D vs 69% national average)  
  – 50% of dementia cases are undiagnosed, with limited support for people and their families post diagnosis |
|                                 | High prevalence of smoking (23.1% vs 17.3% London), alcohol abuse (Barking & Dagenham 7% harmful, 17% high risk, 14% binge drinkers) and obesity (63.3% in B&D vs 57.3% London) | High hospital admission rates  
  – Higher than average unplanned hospitalisation for chronic ambulatory care sensitive conditions (898 per 100,000 pop vs national average 784 per 100,000) |
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<tr>
<th>System level</th>
<th>BHRUT currently in special measures</th>
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<tr>
<td></td>
<td>High number of GPs approaching retirement age</td>
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<td>Unhelpful structures and governance arrangements in general practice, which inhibit whole-system working</td>
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<td>Primary care quality and access (active programme of work including Prime Minister’s Challenge Fund for out-of-hours access)</td>
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<tr>
<th>Funding and efficiency challenges</th>
<th>Funding gap</th>
<th>BHR total funding gap of £429.9m by 2018/19</th>
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<tr>
<td>Efficiency</td>
<td></td>
<td>BHRUT has:</td>
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<td>o High non-elective admissions rate (41% emergency admissions as a percent of total admissions vs 35% England, 33% London)</td>
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<td>o High occupancy levels (94.7% vs 86.9% England average)</td>
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<td>All three BHR CCGs have higher than average inpatient spend for over 75s (e.g. B&amp;D gastro is 6.5 per 100,000 pop higher than comparable CCGs; respiratory is 5.5 per 100,000 higher; and gastro intestinal is 5.5 per 100,000 higher)</td>
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Despite these gaps, BHR has a strong opportunity to successfully deliver the ACO programme. There is a history of partnership working and collaboration across health and social care for the benefit of the population. In May 2012, the system leaders created an Integrated Care Coalition to bring together the lead organisations in the health and social care economy to support the commissioning of integrated care. This was in response to significant pressure experienced across the system, particularly at BHRUT, resulting in non-delivery of key access targets and the resultant deficits in quality and outcome. The Coalition created the partnership imperative to work collectively towards achieving system sustainability. The recent designation as an urgent and emergency care vanguard reflects the commitment to new models of care and transforming ways of working, as well as providing an essential building block for the ACO programme. This includes a capitated budget for approximately 40-50% of health spend, and is coterminous with the proposed ACO population coverage. In addition, Care City provides unique access to innovation across health and social care; evaluation expertise and cutting-edge research; education programmes to increase the resilience of the workforce and forums for shared learning that will further enhance delivery and insights for both the benefit of the programme locally, and for dissemination nationally. UCLPartners, the local Academic Health Science Partnership, has committed to supporting the development of the ACO in BHR and will provide critical links to policy and thought-leaders across the system for the essential enablers of regulation, workforce and new financial flows, as well as enhancing evaluation, dissemination and shared learning.
Proposal

To create an Accountable Care Organisation across the three boroughs in BHR, covering the full 750,000 population they serve and piloting the integration of health and social care across a sector as set out in the London Proposition (September 2015). The ACO will have delegated authority to deliver care for the population and achieve identified measurable health and wellbeing outcomes, within the defined budget. The defined aims of the ACO will link to wider social determinants of health, such as financial stability, housing, education, and employment but as these areas would be outside of the partnership’s control, it could not be held accountable for them. Ultimately this moves away from existing contractual arrangements and brings local commissioners and providers together in one organisation with a strong focus on a robust system of primary care and combined with stronger system regulation. Specifically, the total budget includes all BHR health, adult social care and public health expenditure. The principle underpinning the ACO has been to include all services to ensure maximum scope for radical reform at pace and scale, unless there is a strong rationale to exclude them. Exclusions will be reviewed and confirmed during the business planning process.

In practice this will have profound implications for the way services and system partners work together for the benefit of the population. The funding and efficiency gap requires new incentives across the system to free up capacity in acute trusts (where the largest gap exists) for investment in primary and community interventions and a strong emphasis on prevention and self-care. With one of the highest non-elective admission rates and longer than average lengths of stay, much of the existing BHR system strategy is channelled to reducing this, including the urgent and emergency care vanguard. Where acute trusts are absorbing the impact of system gaps, admitting patients that could be more appropriately supported in the community, the aligned incentives of an ACO can radically change the focus of each of the care giving organisations, change how funding is allocated, and fundamentally address the efficiency challenge. See table under ‘Impact’ section below for specific examples. Intervening much earlier through population interventions or in primary care for those with known risk factors would dramatically improve population health outcomes and value. This has been demonstrated through UCLPartners’ work to improve how atrial fibrillation (a common cause of stroke) is identified and treated in primary care, and is just one example of how improving quality and shifting resources upstream can reduce costly hospital admissions while also improving outcomes and patient experience. A similar approach targeting the most common causes of hospital admission (e.g. exacerbation of long-term conditions) could equate to 20-30% impact on the hospital bed base, and as such is a critical enabler to meeting the £22bn challenge across the NHS.
To achieve impact at significant pace and scale, the delivery will be staged over three years. Underpinning delivery are the following principles:

- **Population focused:** Active dialogue with the population throughout all stages of the programme, and co-designing with staff from the outset, will ensure that the emerging transformations are focused on maximising benefit to the population and grounded in the reality of the front-line changes required. This will require consideration of the wider social needs of the population, such as autonomy and social economic participation in order to improve health and wellbeing. This also requires a strong focus on developing primary care, and there is important learning from local initiatives, such as the complex care practice in primary care (Health 1000), to inform plans for extensive local engagement including with key frontline staff such as local GPs. The recent reconfiguration of cancer and cardiac services reinforces BHR’s commitment to extensive and effective public engagement. By starting with the population need rather than discrete disease pathways, the ACO has greater opportunity to redefine how budgets are spent and to remove both fragmentation and duplication from the bottom up.

- **Aligned incentives:** A new approach to leadership and governance will be essential for ensuring the whole system participates in driving change. This will build a whole population partnership ethos where the ACO drives collective responsibility across all settings of care to maximise community-based support and minimise reliance on acute settings. The existing system-wide partnership in BHR, and the leadership support and ownership of the ACO model development are strong foundations. In the first two years, the ACO will run in shadow form as a governing body hosted by one of the local authority partners. The budget will run in shadow form in year one, be launched for certain cohorts of the population in year two, and move to full operational status by year three. By the end of the three-year programme, the ambition is for the ACO to be a fully constituted, independent organisation with accountability for the £1.2bn budget.

- **A staged approach:** In order to maximise opportunities, but not destabilise the system in the short term, the programme will be delivered in three stages:
  
  - **Stage 1: Consistency** - ensuring that across all three boroughs the commissioning approach and content is consistent, to create a common platform on which to progress, whilst in parallel conducting detailed planning of the ACO implementation.
  
  - **Stage 2: Evolution** – building on the urgent and emergency care vanguard and other priority population groupings, combined budgets will run in shadow form.
Stage 3: Transformation – transition from shadow budgets to full budget accountability, building in parallel the required governance and organisational framework to support delivery.

- **Embedded academia:** Academic Medical Centres (AMCs) have traditionally built alignment of strategic focus, resources, and critical mass of expertise across NHS and university partners, facilitated by high-volume patient flows in specialist areas to enable world-class research, translation, implementation, care and education. The new ACO will build on the benefits of this integration with academia from the beginning and reinforce the population health ambition. Specifically it will deliver a ‘4P’ approach:
  - **Preventative** - interrupting the mechanisms responsible for disease before it manifests
  - **Predictive** - using genomic and phenotypic systems to predict risk
  - **Personalised** - tailoring to the individual’s biological make-up, lifestyle and beliefs
  - **Participatory** - creating services in collaboration with patients to encourage ownership and ensure treatments and interventions are effective for them.

Population outcomes are the aligning mechanism across the system and, as such, delivery of population health and wellbeing interventions and prevention will be pivotal to success. There is also an important role in ensuring education and training reflect the latest evidence and reinforce the future context under an ACO. Alongside using evidence and research to inform and shape interventions, UCLPartners and the NIHR North Thames CLAHRC bring world class and diverse multidisciplinary expertise (e.g. in statistics, modelling, health economics, behavioural change, organisational research, participatory inquiry and health care evaluation) to co-design and evaluate the delivery of both the ACO model and its effectiveness in closing the three gaps (health and wellbeing, care and quality, funding and efficiency).

- **Shared learning:** The ACO will be a learning organisation. To support development of further ACO models across London (and beyond) in rapid succession, progress and learnings will be transparent and shared in appropriate formats and forums on a regular basis. Partnership working with the national new models of care programme will ensure the ACO benefits from, and contributes to, lessons from the vanguards (including the multi-specialty community providers, primary and acute care systems, and the urgent and emergency care vanguard that BHR are participating in). Academic partners will have an important role to embed robust evaluation from the outset as described above.
Impact

The outcomes set by the ACO will be the foundation for both budget monitoring and regulation. As such, these will be metrics that are sensitive to change in the next three years, set in the context of longer term aspirations, but more focused to drive transformation in models of care.

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<tr>
<th>Benefit</th>
<th>Outcomes</th>
<th>Unique contribution of ACO</th>
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<tbody>
<tr>
<td><strong>Addressing the health and wellbeing gap</strong></td>
<td>Population</td>
<td>Increased and consistent support for evidence-based behaviour change, activating residents to protect and improve their health and wellbeing, focused on diet, smoking and alcohol</td>
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<td>Increased coverage and take up of screening and immunisations.</td>
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<tr>
<td><strong>Addressing the care and quality gap</strong></td>
<td>Disease prevalence</td>
<td>Earlier detection of cancer, cardiac disease, hypertension, diabetes and dementia</td>
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<td>Reduction in admissions for long-term conditions (particularly diabetes, COPD)</td>
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<td>Reduction in avoidable variation in admissions to hospitals.</td>
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<td>System level</td>
<td>BHRUT out of special measures</td>
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<td></td>
<td></td>
<td>New models of care to support management in primary care.</td>
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<tr>
<td><strong>Addressing the funding and efficiency gap</strong></td>
<td>Funding gap</td>
<td>Sustainable system – finance and service delivery.</td>
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<tr>
<td>Efficiency</td>
<td></td>
<td>Reduction in non-elective admissions</td>
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<td>Reduction in length of stay in hospital.</td>
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Enablers

Alongside the ACO implementation there are three enablers that will need to be developed in partnership with national bodies to ensure success of the model: reforming regulation, development of new workforce models, and ongoing utilisation of the informatics platform.

Regulation (external)

The role of regulation is particularly pivotal to success given the aspiration for the ACO to move away from traditional commissioner functions towards incorporating population budgetary management and service provision in one organisation. While the ACO will strengthen local accountability there will also need to be a separate regulatory framework for the ACO activities covering the population served, which takes account of and complements the existing regulatory frameworks for each organisation (be that primary or secondary care, etc.) who will continue to be responsible for activities undertaken within their own institution, and likely continue to provide services to populations from outside the ACO. This new framework will need to reinforce the behaviours required across the system to ensure successful delivery of the outcomes at a population level, and will need to be sensitive to competing priorities at an organisation and system level. The focus will be on population outcomes. For example: What is the reduction in premature mortality in patients with mental health problems, cardiovascular disease, or cancer? What is the change in patient experience and patient reported outcomes along whole pathways of care, including at the “handoffs” between providers (which are currently poorly regulated)? What was the shift achieved from acute care to community care and prevention/earlier diagnosis? What has been done to achieve better value for money for the population served?

Organisations will be accountable separately for each clinical service they provide (as now), but with an ACO Board accountable for population health gain and thereby ensuring delivery of integrated services with the desired outcomes across organisations and within the overall ACO budget. With clear, aligned but different accountabilities between the ACO and the individual providers, clinical governance will be enhanced. At the moment, for example, accountability is clear within an organisation but it is unclear between them. This approach would attempt to cement both, and encourage a focus on generating alignment and accelerating co-ordinated delivery. Strong mutual support and partnership working across boundaries, with the right incentives, oversight and decision-making, will be needed to create local governance and engagement to drive improvements and overcome institutionally entrenched ways of working. For traction, the delivery of the ACO would need to feature proportionally as a key metric in the performance assessment of each of the separate organisations by their own regulators (Monitor and CQC). As the system regulation becomes established, individual organisation regulation will reduce to ensure there is not an increase in the overall burden of regulation. Active dialogues with CQC and
Monitor are ensuring commitment to developing a system wide regulation approach and new financial models that will provide the required incentives for the ACO to be successful.

**Workforce (external and internal)**

The implications of an ACO model on the workforce should not be underestimated and all types of staff - from front line teams through to organisational and system leadership - will be affected. This change will be apparent on several levels: culturally, operationally and professionally. Changing mind sets and behaviours to reinforce the collective responsibility for prevention and early treatment in all staff will be one step towards developing the ACO.

However, more fundamental is the need to develop the workforce for the future. In particular, increasing emphasis and investment in primary care and in community care and services to support people to accept responsibility for their health and to live independently at home, will give renewed opportunities to explore new staff roles. By removing the distinction between settings of care that exist in our current system, there is scope to merge the responsibilities and develop multidisciplinary skills in individuals. For example, developing care workers with occupational therapy and physiotherapy skills to provide more holistic support and reduce the need for multiple members of staff with overlapping remits. This approach also has potential benefits in providing health through wealth, by improving employment for local people.

Equally the leadership of ACOs will require a new cohort of ‘system leaders’ who are skilled at multi-agency and multi-disciplinary partnership working towards the delivery of population outcomes and system-wide sustainability. With a focus on improving whole pathways of care, rather than individual institutions, our experience from our specialist cancer reconfiguration is that the ACO should appeal to clinical leaders and align with professional values common to the workforce. Partnership working with Health Education England (HEE) will be critical to success, to ensure that the ACO can help shape and access the emerging development offer. The regional and national offices of HEE have indicated support for multi-professional training and leadership development.

**Informatics (internal)**

International examples demonstrate the value of investing in informatics infrastructure to drive population intelligence and surveillance, to target interventions, and to improve efficiency of care delivery through ensuring teams have access to the right information, utilising alert systems and operational tools, and promoting personalisation, pre-emptive intervention, and enhanced self-management of long-term conditions. BHR has a strong track record of using population health analysis
through the health analytics system. Since 2011, data sharing agreements, information governance, technical, and clinical data standards have been put in place to create one of the most advanced integrated clinical and social electronic shared care records in the UK. In October 2013 it achieved accredited safe haven status (ASH). The architecture supports data sharing across all settings of care (184 GP practices, hospital, community, mental health and social care organisations) matching data using the NHS number. There are ongoing developments; two recent examples being the linkages to the Orion clinical portal to enhance the real time sharing of clinical data, and the development of shared care plans to support integration. This provides essential foundations for the ACO, both to drive operational efficiency, and to support tracking of impact and regulatory work. In addition, the urgent and emergency care vanguard will ensure better alignment of digital channels to improve access, better manage demand and service delivery. Through Care City and UCLPartners, BHR is uniquely placed to benefit from fast track access to innovations in digital health which will further accelerate progress.

Timescale
Next steps

On approval from NHS England, the immediate actions for the BHR ACO will be to:

- Confirm infrastructure for programme delivery, led by SROs Cheryl Coppell, Chief Executive, London Borough of Havering and Conor Burke Chief Officer, Barking and Dagenham, Havering and Redbridge CCGs and BHR Integrated Care Coalition – October 2015
- Develop MOU with NHS England - October 2015
- Ongoing discussions with CQC, NHS improvement (Monitor), HEE and NHS England, led by UCLPartners, and in tandem with the national vanguards to confirm commitment to the programme - October 2015
- Identify appropriate Principle Investigators (PIs) and funding sources for the ACO evaluation- by April 2016
- Produce business case for submission to NHS England - by June 2016

With the necessary support and backing, BHR has the elements needed to create a successful ACO and transform the quality and value of care for a whole region.

Submitted by:

BHR Integrated Care Coalition and UCLPartners

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1 Adult social care and public health expenditure has been included for Local Authority budgets (30-50% of total LA budget), and all CCG expenditure. During business planning, these budgets will be interrogated in more detail, with further discussion on broader expenditure, as well as any exclusions from health spend.
2 Further challenges were identified by the local partnership groups and are described in the BHR PowerPoint proposal document (September 2015)
6 Care City is a centre for innovation, research, and education set up to deliver a dual mission of measurable improvements in healthy ageing and social regeneration. It covers a 1m population across four boroughs – Barking and Dagenham, Havering, Redbridge and Waltham Forest and brings together health, social care, and third sector partners from across the system with researchers, education providers, technology experts, small and medium companies and social entrepreneurs to develop the healthcare and workforce models for the future. Further information is available at www.carecity.london